MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

EMPLOYEE SANCTIONS FOR RELEASES OF PROTECTED HEALTH INFORMATION

Effective Date: June 6, 2003 **Policy #:** HI-15

I. PURPOSE: This policy addresses disciplinary action to be taken toward MSH employees who release Protected Health Information (PHI) in violation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and DPHHS/MSH policies.

II. POLICY: Employees of MSH must abide by the policies concerning the uses and disclosures of PHI. Uses and disclosures that violate these policies will be subject to disciplinary action in accordance with Montana State Hospital and DPHHS disciplinary procedures and bargaining unit contracts.

III. DEFINITIONS: None

IV. RESPONSIBILITIES:

A. Employees must immediately notify their supervisor when having used or disclosed PHI inappropriately or outside the guidelines established by HIPAA policies.

B. The Supervisor must determine, by discussion with the employee, whether the employee's use or disclosure was intentional or malicious. The Supervisor will document any training determined necessary or disciplinary action taken and notify the Privacy Officer.

C. The Director of Information Resources is the designated MSH Privacy Officer. The Privacy Officer or designee will maintain a log of all improper uses and disclosures of PHI and report intentional or malicious uses of PHI to the Office for Civil Rights.

V. PROCEDURE:

A. A first time use or disclosure that is not determined to be intentional or malicious by the supervisor, will be managed with appropriate disciplinary action, such as verbal or written counseling and will be accompanied with additional training in MSH & DPHHS privacy policies. A supervisor may also determine that other disciplinary or training steps may be appropriate.

B. A use or disclosure that is a repeat occurrence, or which occurs for more than one client, will be subject to the next level of disciplinary action as deemed appropriate by the supervisor.

C. If the supervisor determines that the improper use or disclosure of PHI has been intentional or malicious, the supervisor must apply disciplinary action commensurate the incident, up to and including termination from employment with MSH.

D. If the supervisor is notified of an improper use or disclosure of PHI by someone other than the employee in question, the supervisor must determine from the employee the circumstances of the use or disclosure and why the employee did not notify the supervisor. The above guidelines for appropriate disciplinary action will apply, as well as a discussion of the need for MSH to mitigate the risks resulting from such uses or disclosures.

E. In all cases, MSH supervisors must document disciplinary and corrective actions in the employee personnel file in accordance with the terms of the employee's collective bargaining agreement or other applicable MSH/DPHHS policies. Documents in the personnel file pertaining to specific disclosure of PHI will be sufficient to comply with the requirements of 45CFR 164.530(c) (2), which may need to be made available to the Office for Civil Rights if they are investigating a complaint concerning the employee. The Personnel Officer must approve release of specific documents from employee's personnel file.

F. Supervisors must also make the Privacy Officer aware of any improper uses and disclosures so that appropriate risk management procedures may take place. The MSH Privacy Officer will confer with the Hospital Administrator and/or the Department Supervisor and the DPHHS Privacy Officer to plan appropriate steps to mitigate risks presented by the improper uses or disclosures.

G. The MSH Privacy Officer or designee shall log all improper uses and disclosures on a disclosure log. This log will be made available to the client for review if requested.

H. The Privacy Officer must review serious intentional or malicious uses and disclosures of PHI to determine if such employees should be reported to the Office for Civil Rights for potential civil or criminal penalties.

VI. REFERENCES: DPHHS HIPAA Privacy Policies, HIPAA privacy rules

VII. COLLABORATED WITH: DPHHS Privacy Officer, MSH Personnel Officer

VIII. RESCISSIONS: None, new policy

IX. DISTRIBUTION: All hospital policy manuals

X. REVIEW AND REISSUE DATE: June 2006

XI. FOLLOW-UP RESPONSIBILITY: MSH Privacy Officer

XII. ATTACHMENTS: None

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Ed Amberg Date	Billie Holmlund Date
Hospital Administrator	Director of Information Resources